Ilkley Health Care Limited

Riverview Nursing Home

Inspection report

Stourton Road
Ilkley
West Yorkshire
LS29 9BG

Tel: 01943602352

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place 14 April 2016 and was unannounced.

The home provides personal and nursing care for up to 60 older people. It is a large converted property and is located close to the town centre of Ilkley. The accommodation is on four floors and consists of shared and single rooms of which 17 have ensuite facilities. There are two passenger lifts giving access to all areas. Most of the communal areas are on the ground floor, there is one lounge on the first floor. There are gardens which are accessible to people.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff knew how to recognise abuse and report a safeguarding concern. Some recent safeguarding incidents had not been dealt with by management.

We saw sufficient staff deployed to keep people safe. At busy times staff were very task orientated and could not always respond to people's needs in the most effective way.

Staff had applied for the post, been interviewed and had all relevant background checks completed before starting to work alone.

People were assessed for risk for their health and wellbeing. However as people's risks changed, this was not always recorded on risk assessment documentation.

Staff had completed mandatory training to enable them to complete their roles effectively. Further training courses were available to support people in a more effective way.

We had positive feedback about the food offered. We observed people had a choice of hot or cold food for breakfast. Menus were only displayed on the ground floor.

People had been referred to health care professionals in a timely fashion. Healthcare professionals told us they had a positive relationship and worked closely with the home.

Deprivation of Liberty Safeguards authorisations had been completed correctly and the home carried the correct paperwork. However there was a cumulative effect for other restrictions on people that had not been referred.

People told us and we saw that people were treated with privacy and dignity. People said staff were very

caring and they would help as much as they could.

Relatives told us they had been involved in the planning of care. Care records for people had been signed by relatives. Minutes from best interest meetings were also evident.

We asked staff about the people they supported. They told us specific detail about people and how they liked their support. This showed us a good understanding of the people they supported.

The home benefitted from an activities co-ordinator. One of the communal areas on the ground floor listed activities for the day. The first floor lounge was very quiet with music and TV playing all day.

Care records had not always been completed or reviewed to reflect people's current needs. We saw some care records had identified changes, but these changes had not happened.

People and relatives told us they knew how to make a complaint. We saw the registered manager had acted on previous complaints in line with the provider's policy.

The culture of the environment was different depending on where in the home you were. The ground floor had a livelier atmosphere with more light, contemporary decoration and more happening. The first floor appeared very quiet with not much to do.

Audits had been completed by the provider and the registered manager. Some audits had not been completed in a robust way, or reacted to in a timely fashion. This left some people at potential risk.

People told us they had regular meetings to pass their views on about the home. Staff had team meeting planned in and relatives had four meetings a year in order to constantly improve.

We found three breech's of the Health and Social Care Act (2008) Regulated Activities Regulations 2014. You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff knew how to report a safeguarding, however some recent safeguarding incidents had not been alerted to the adult protection team.

There was sufficient staff to keep people safe, but staff were task orientated and could not always deal with people's needs as they wished.

Staff had been recruited in a safe way.

People had any risks to them assessed. However as peoples risks changed, this was not always recorded on risk assessment documentation.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had completed mandatory training to enable them to complete their roles effectively.

People told us food was nice. Although equipment to support people to eat independently was not available. Menus were only displayed on the ground floor.

People were referred to other health care professionals in a timely fashion. Healthcare professionals told us they had a positive relationship with the home.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed and people told us they were treated with privacy and dignity.

Relatives told us they had been involved in the planning of care.

Staff had a clear and detailed knowledge of people.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The ground floor had advertised activities for the day, with the activities coordinator based there. The first floor lounge was very quiet with music and TV.

Care records had not always been completed or reviewed to reflect people's current needs.

People and relatives told us they knew how to make a complaint. We saw the registered manager had acted on previous complaints in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The culture and atmosphere was different depending on where in the home you lived.

Audits had been completed. Some audits had not been completed in a robust way, or reacted to in a timely fashion. This left some people at potential risk.

People told us they had regular meetings to pass their views on about the home. Staff had team meeting planned in and relatives had four meetings a year in order to constantly improve.

Riverview Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 April 2016. This inspection was unannounced. The last inspection took place on 5 November 2014 and the provider was meeting the regulations in all areas inspected against and was rated as providing a good service.

The inspection team consisted of two inspectors, one specialist advisor for pharmacy, one specialist advisor for mental health and an expert by experience.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with 12 people who used the service four relatives to ask them for their views on the service. In addition we spoke with three care workers, one senior lead, two visiting health professionals and the registered manager. We looked at five people's care records and other records which related to the management of the service such as training records and policies and procedures.

On this occasion, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we reviewed all information we held about the provider and contacted the local authority to ask for their views on the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives said that they felt safe at Riverview. Relatives comments included, "I always feel [person's name] is safe here, I can leave them knowing they will be fine;" and, "They're definitely safe, yes." People told us they were happy with the promptness of staff and their response to call bells.

Staff we spoke with understood safeguarding and how to report it. Staff were able to explain in detail the process of reporting a safeguarding concern and what action they would take if they felt people were still at risk, however they felt confident the management would always act appropriately. The registered manager showed us the safeguarding file for incidents that had been reported in 2016. The file contained one safeguarding incident which had been referred to the local authority safeguarding team and notified to CQC. The record showed appropriate action had been taken in response to the incident. However, when looking through the accident reports for March 2016 we found a further three safeguarding incidents. We discussed these with the registered manager who was unaware these incidents had occurred as they said they had not reviewed the accident records and staff had not reported these incidents to them. All three incidents related to the same person hitting other people. At the end of the inspection the registered manager told us they had spoken with a healthcare professional who was going to review the person's medication. They also said they were now going to put a system in place to make sure all accident reports came to the registered manager on a daily basis. However, we were concerned that these incidents had not been reported, identified or dealt with until we brought them to the registered manager's attention which meant that people had experienced physical abuse when this may have been prevented if the issues had been identified earlier.

This was a breach of Regulation 13 (2) (3) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

Staff we spoke with felt there was enough staff and said they always made sure there was a staff member in the lounges on both floors. We observed a staff presence was maintained in the upstairs lounge however there was no call bell in this room which meant people who used the service and staff had no way of summoning staff assistance. We were present when one person spilt a cup of tea over themselves; the staff member in the room responded promptly but needed help from other staff which meant they had to leave the room unattended while they went to find staff. If a call bell had been available the staff member would have been able to summoned help and remain with the person until staff arrived. We found a number of people's bedrooms without a call bell present, or at least without it connected. One person told us they had no means of calling for staff and we found an unattached call lead on the floor out of the reach of the person in bed. We brought this to the attention of the registered manager who took immediate action. We spoke with a relative who felt that there was insufficient staff and that 'quite a few' had moved on recently. We observed during the quieter periods of the day there was sufficient staff to support people's needs, but during busier times of the day, for example meal times, staff were target orientated leaving it difficult for people to ask for assistance if they required it.

This was a breach of Regulation 17 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities 2014)

Regulations.

Staff were recruited in a safe way. Safe recruitment procedures were in place and followed by management. Staff files showed completed application forms detailing previous employment and qualifications. Proof of identity documents were on file. Checks on people's backgrounds took place including ensuring a Disclosure and Barring Service (DBS) check and references were undertaken. The DBS is a background check conducted on potential staff to show they are safe to work with vulnerable adults. Staff confirmed the recruitment process they followed when applying for a role at Riverview.

Potential risks to people's safety and welfare who lived at the home had been identified and steps taken to minimise them. Some of the risk assessments for people were joined with the care record for the same subject. For example care records and risk assessments for behaviour assessment, environmental, communication, emotional needs and oral health. Risks identified the potential risk with each activity, a risk rating was applied and prevention methods to be implemented. We saw individual risk assessments in place for the risk of falls, developing pressure ulcers, nutritional risks and for the risks associated with moving and handling. Information in people's care plans showed how these risks were managed. However, one person's falls risk assessment had not been fully completed although the risk of falling was assessed as high. Accident reports showed this person had sustained four falls in April 2016, yet there had been no review of the risk assessment and there was limited information to show how these risks were being managed. For example, the care plan stated 'one staff to walk with, uses zimmer' and 'if fall, trip or slip, nurse to complete body check'.

We completed a tour of the premises as part of our inspection. All radiators in the home were covered to protect vulnerable people from the risk of injury. Hot water taps were controlled by thermostatic valves that protected people from the risk of scalds. We saw all portable electrical equipment had been tested and carried confirmation of the test and the date it was carried out. All cleaning materials and disinfectants were kept in a locked room out of the reach of vulnerable people. We saw fire-fighting equipment was available and emergency lighting was in place. We saw some aspects of fire safety was not being followed. For example, one fire door had a sign indicating the door was to be kept locked shut. The door had no door catch and the room was unlocked. We also found one fire escape at the rear of the property was obstructed by the area being used to store wheelchairs and other such pieces of equipment. We found whilst some shared bedrooms had dividing curtains, we found others did not. This meant people's privacy and dignity might have been compromised in shared bedrooms.

We looked at how the home responded to potential risks of cross infection. We saw anti-bacterial gel dispensers were located throughout the home. We observed staff washed their hands between tasks and had disposable gloves and aprons to support people with their personal care tasks. Staff had undertaken training in infection prevention and control. This meant the staff had the knowledge and information they needed to minimise the risk of the spread of infection which they demonstrated during the day of our inspection as they carried out practical tasks. We spoke with a domestic staff about the arrangements for keeping the home clean and hygienic. They described the colour-coded protocol for separation of cleaning materials and equipment to ensure toilets were cleaned with cloths not used in other areas. The cleaner's description and application of the protocol demonstrated safe practice. We were told there were adequate supplies of cleaning products and protective clothing at all times. The cleaner had access to procedures which described which product should be used for each surface and the dilution strengths of cleaning liquids.

Medicines were generally handled in a safe manner, with many examples of good practice. Administration of medicines to people was safe, compassionate and thoughtful. Most medicines were in blister packs

which were updated monthly and a new printed Medication Administration Record (MAR) chart supplied. Any additional medicines required were provided rapidly and often on the same day as requested. Medicines that could not be supplied in blisters were in named boxes/bottles. The quantities of medicines remaining in boxes/bottles was documented after each administration. There were helpful reminder labels on the MAR charts when medicines were supplied in boxes or bottles.

We found nurses administered medicines in a safe way. They did not sign the MAR chart until they had witnessed the resident taking the dose. The nurses gave people time to take their medicines and were not rushed and consistently enquired about the need of 'when required' medicines. The documentation of 'when required' medicines appeared to be very thorough, with most doses having an entry on the MAR chart even when the dose was not required.

Medicines that have a limited shelf life after opening were dated with the date of opening. There was a list of signatures of nurses eligible to administer medicines at the front of the MAR charts. Medicines were appropriately stored in locked cupboards, a fridge or controlled drug (CD) cabinet. Medicines awaiting destruction were stored in a sharps bin and documented in a destruction book. The temperature of the medicines room was documented daily and was less than 25 degrees. The controlled drug registers were complete and stock checks were undertaken on a regular basis. All CDs were counted and all tallied with the CD register entry.

However there were some discrepancies in the documentation of allergies. Information printed in red beneath the resident's photograph in the MAR chart folder did not always correlate with information on the MAR chart supplied from the pharmacy. The documentation and counting of PRN medicines and other boxed medicines was generally very good but was not consistent. Some quantities are documented on the MAR chart and others on a Balance Record Form.

The covert administration of medicines could be used with several people but documentation of the authority to use covert techniques was poor. One person had a hand written note in their MAR chart. Several other people had a completed 'Covert Medication Care Pathway' form completed by a GP but there had been no input from a pharmacist. We saw no evidence of an agreed review process. The registered manager assured us the current arrangements for the administration of covert medicines to five people would be subject to urgent review with adherence to the guidance contained in the National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes'.

We saw two tins of thickening agent were on the mantelpiece in the upstairs lounge with no prescription labels on. When we asked staff if any of the people in the lounge had this thickening agent they said no. Thickening agents are prescribed medicines for individual use only and a NHS England patient safety alert in January 2015 identified the risks of asphyxiation if the powder was accidentally swallowed. We discussed this with the registered manager who said they would remove these and ensure they were stored out of reach.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us they had the skills and knowledge to meet the needs of people who used the service. One staff member told us, "We definitely have enough training to do our jobs safely." Other staff said the registered manager supported them in their roles and carried out regular supervision with them where training needs were discussed. This was confirmed in supervision records we reviewed. The training matrix showed staff were up-to-date with the majority of training. We identified a small number of staff who required updates in moving and handling and fire safety. The registered manager told us these updates were planned for June and they would ensure these staff attended.

We made observations around the home during the morning and saw people were provided with breakfast as they got up and had a plentiful supply of drinks throughout the morning. We saw one person was brought two hash browns in a bowl for breakfast and the staff member told us they ate 'finger foods'. We asked the person if they were enjoying them and they said, "It's all right, not what I'd have at home." When we asked what they would have at home they said, "Thin toast. I like it thin." We saw one person was brought a jam sandwich and when they said they didn't want it staff asked if they would like some toast and brought it.

We observed lunch and saw people were brought their meals. When we asked staff how they knew what people wanted for lunch we were shown a board which listed people's names under one of three headings – normal, puree and soft. Staff told us those who had 'normal' diets or finger foods had chicken and mushroom pie and curly fries, those who had soft diets had mince, mash and vegetables and puree diet was the same mince meal but with all parts pureed. Staff clearly knew individual residents and were usually responsive to their needs when these were communicated. Meals served in dining room appeared warm and appetising and were served promptly. We saw one staff member say, "This is your dinner [Person's name], as you requested." We overheard another person say, "This is nice." One relative commented positively about the food. We observed staff awareness of one person's diabetes when snacks/ meals were being provided. A regular provision of drinks/ snacks between mealtimes throughout the day was served.

We saw there was no menu in the upstairs lounge, staff told us this was displayed downstairs. People had drinks but there were no condiments and none were offered. In one lounge each person was sat in an armchair with a bed table in front of them and all had clothing protectors on. We saw some people struggled to eat their meals in this position. For example, one person had to pull themselves forward each time to reach the plate of food and then fell back when they were transferring a spoonful to their mouth resulting in food dropping onto their clothes and down their chin. Another person tried to scoop their food up from the plate with a spoon which resulted in the food piling up at the edge of the plate. We saw the person repeatedly extending the spoon to the table and scrapping the table and plate to get more food but couldn't see that the food had all gathered at the edge and eventually just put the spoon down. A staff member was present and noticed the person scraping the table with their spoon and said, "Use your plate (Name)." They hadn't noticed that the person was having difficulty. There were no plate guards or other aids to help people. Staff told us there were two people in the lounge who required assistance with eating. We saw a staff member sat with one person and they calmly and patiently supported the person to eat their meal. We felt this was partly due to the target orientated tasks to be completed during the busy periods of

the day.

This was a breach of Regulation 9 (3) (b) (h) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

We saw appropriate and timely referrals had been made to health professionals when people's needs had changed. Evidence of involvement with GP's, hospital consultants, community psychiatric nurses (CPN), specialist nurses in the field of tissue viability, speech and language therapists and dentists was evident. Care records were set out clearly to allow staff easy access to health care professional's written advice. We spoke with a CPN who regularly visited the home. They told us their instructions and advice was acted upon. Care records we looked at showed care staff acted promptly to ask for professional advice.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We were told one person was subject to DoLS which had four conditions attached. Scrutiny of the person's care records showed the conditions had been translated into the care records and were being followed We were told a further nine authorisations had been requested. However our observations of the environment and other people's care records suggested the provider utilised a number of methods which may constitute a deprivation of liberty. The front door was locked. Some care records recorded diagnoses and other indications of reduced mental capacity. Some people were under regular observations with people's activity recorded and others were assessed to need observations during the night. Whilst each element of restrictions may not constitute a deprivation of liberty, it may be the case that the accumulation of restrictions being experienced by some people may amount to unauthorised deprivation of their liberty. Discussion with a CPN who had a comprehensive understanding of many people's needs agreed with our assumption that some people who were currently without DoLS should have an authorisation submitted. A further discussion with the registered manager concluded more people were in need of DoLS than was currently the case. The registered manager assured us they would commence the process of assessment and if required submit authorisations to the supervisory body.

We toured the building during the day of inspection. Although some effort had been made to make the home dementia friendly, certain aspects had been overlooked. For example the use of colour and contrast can be helpful for people with dementia but heavily patterned wallpaper and fabric should be avoided. We found some carpets to be heavily patterned but the registered manager told us these were to be replaced with plain carpets. However we found other areas which had been more recently refurbished had ignored the use of contrasting colours and materials. For example, when wood-effect vinyl had been used in bedrooms furniture was also plain wood. We saw doors and hand rails painted in a similar colour to the walls which did not make them stand out. When we visited people's rooms we did not see labelled drawers, cupboards and doors to show people what is inside them. The registered manager had made us aware prior to inspection they were undergoing a large refurbishment and a works plan had been completed.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with were positive about the staff and told us they were caring. One person told us, "They look after you," and another person told us," Yes it is quite good here. I have everything I need and there is very little to complain about." Two relatives told us they were very happy with the care their family member received. They said the nurses were excellent and they found all the staff to be caring. We observed staff were kind and caring in their interactions with people.

Interactions we observed between people and staff were calm, kind and often thoughtful. For example one staff member sat with and comforted one person who was distressed for a period in a communal area. Another staff member supported a person sensitively when helping them to choose a drink. Staff and the registered manager dealt swiftly and kindly with a person who fell to the floor. However, we observed some practices which compromised people's dignity. For example, we saw one person in the lounge being hoisted by staff into a chair and their clothing had ridden up exposing their underwear. When sat in the chair this person's legs were exposed to the top of their thighs and although staff brought a blanket to put over their legs the person removed this saying it was too hot. We saw one staff member repeatedly tried to adjust this person's clothing and cover their legs but no one considered supporting the person to change into different clothes.

We saw two people in beds next to each other in a shared room and there was no curtain between the bed to maintain each person's privacy and dignity. We found the furniture and chairs in the upstairs lounge was not clean. There was food engrained on some of the bed tables and stains down the sides of some of the chairs.

The staff we spoke with spoke respectfully about the people they cared for. They talked of respecting people and ensuring their diverse needs were being met. All staff we spoke with demonstrated a good knowledge of people's individual needs and wishes. We asked staff about people's routines and what was important to them. Staff were able to tell us about what people liked and how they liked it. This showed us that positive caring relationships had been developed between people and staff.

Staff also commented on the need to support people to be more independent where they could. We saw examples of staff directing people to do things, but not immediately doing it for them. This allowed people to attempt something for themselves before support arrived. Daily notes documented for staff to encourage people to take part in activities and daily life. We observed one person following a member of staff. We saw the staff member shared a joke about following them, before asking if they wanted something to do. This person was then supported to make drinks for people and take them to them.

Some people we spoke with told us they had been involved in the planning of their care and staff supported them in a way that suited them. Relatives described a good level of involvement in decisions regarding their family members care needs. One relative said that they felt welcome at the home and enjoyed access to visit whenever they liked. Another relative told us, "It feels like I live here too."

We looked specifically at care records for three people around making advanced decisions and consent. Their care records held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional who completed the form. We spoke with staff that knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care and support from staff in a way that they preferred and met their needs. People and relatives said they had attended meetings where support needs had been discussed and agreed. One relative told us, "I get invited to meetings about [person's name] and we have had chats about their life."

We reviewed five people's care records in detail. We found some sections of the care records were well completed. Care records had become more personalised since our last inspection. Care records included relevant history of the person, current support needs, a support summery so new or agency staff don't have to read a whole file before starting and relevant documentation. For example we saw one person's care records included a hospital passport. A hospital passport is a quick guide that explained to hospital staff when admitted about illness and health but also about their likes and dislikes and preferred methods of communication. This can make the experience of the person better. Care records were completed individually covering areas such as dressing, mobility, continence, dementia personal care and behaviour. Where health professionals had advised on areas covered in care records, this was documented.

However we found some sections of care records required updating. This had already been identified by the registered manager in one of the care files we reviewed as there were entries in January 2016 stating the care records needed updating but this had not yet been done. We found it was not always clear what people's current care needs were. For example, one person's daily records from April 2016 said they had three small skin breaks and a dressing had been applied. There was no information about this in the person's care record and no further entries in the daily records about these pressure sores. We asked the nurse who said they were not aware of any pressure sores. They checked with a colleague and told us this person's skin was intact and these breaks had healed. We saw this person was on a pressure relieving mattress and it was set to a weight of 90kgs. The care records showed the person weighed 48.65kgs when they were last weighed on 12 February 2016. This meant the mattress was not at the correct setting to be of therapeutic benefit to the person's.

We saw various activities on during the day, however there appeared to be more opportunity for activities in the downstairs communal area than in the upstairs area. One person told us, "There are more opportunities to do things here than at my last home." Another person told us the activity co-ordinator was very good. On the wall in the communal area downstairs was a weekly planner to inform people what activities were on at different times of the day. On the day of inspection we saw people were encouraged to join in with exercise in the morning with ball games and crafts in the afternoon when people could help prepare for a party to celebrate the Queen's birthday. The homes activities co-ordinator who was very happy, inclusive and encouraging. At other times there was old music playing and staff encouraged people to sing and dance if they wished. We saw some people enjoyed watching a DVD of Singing in the Rain in the upstairs lounge. Yet apart from the television there was nothing to occupy or interest people and although staff sat and chatted when they could, we saw most of the time they were busy attending to people's physical care needs. The registered manager told us there were plans to make the lounge into a sensory room.

We looked at the complaints log, which showed six complaints had been received since January 2015. The records showed the complaints had been investigated and provided details of the complaint, the action taken and the feedback provided to the complainant. Relatives we spoke with had no cause to make complaint, but they told us they would not hesitate to approach registered manager if they had concerns. People told us when that had a problem they would inform staff. We asked staff what action they would take if someone had raised a concern with them. They told us they would document the complaint on the log and make the registered manager aware of the raised concern. One relative reported raising issue of the home's physical state with the registered manager. They told us that the comments were well received and that there have been improvements to standards of decoration in common areas.

Requires Improvement

Is the service well-led?

Our findings

People told us they thought the home was well-run. One person told us, "I see [Registered manager] all the time." Another person told us they had confidence in the registered manager. A staff member told us, "The management are good and supportive. If we need to speak with someone, there is always a way to contact them for advice." Visiting health professionals we spoke with told us they had confidence in the registered manager. On the day of inspection the registered manager was open and honest and supplied the inspection team with all the documentation we required. After the inspection the registered manager was asked to forward some documents on to us. This was done within the specified time frame.

The service worked closely with healthcare and social care professionals, including the local Community Mental Health Team (CMHT) who provided support and advice so staff could support people effectively at the service. Care records were available to the staff and were put away after use. People could be confident that information held by the service about them was kept confidential. The registered manager had a presence in the home and was available to give advice and support.

The registered manager told us accidents and incidents were audited monthly. We reviewed the audits completed since the beginning of January 2016. We found the audits listed the date and time of the incident, location, type (i.e. fall), whether it involved staff or a person, any injury, treatment and if the person attended A&E or was admitted to hospital. The audit identified patterns in times and locations of incidents. However, we found the audits were limited as it was not clear if people were having repeated accidents as names or codes were not used just 'resident' or 'staff'. There was no evidence to show how the information gathered in the audits had been analysed or used to look at 'lessons learnt'. For example, the audits in January and February 2016 both identified the most common time for accidents was between 8pm and 10pm and the most common location was in the lounges. There had been a large increase in accidents from 13 recorded in January to 35 in February and 38 in March. We found some accident reports had not been responded to in a timely fashion. For example we found three accident reports that had not been analysed from March 2016. We spoke with the registered manager about these and they started to action these immediately and created a system so accident forms came straight to a senior or management person on the day it happened. When we discussed this with the registered manager they agreed the analysis needed to improve.

The culture in the home appeared different in different areas. For example on the ground floor the care and support people experienced was more positive than on the first floor. Staff told us people were able to access all parts of the home, but this was difficult for staff to support during busy periods. People told us they enjoyed the atmosphere and liked seeing what was happening. One relative told us, "There is a good atmosphere here."

We spoke with staff and they told us they had a good understanding of their role and responsibilities. Staff said and we observed that they enjoyed their work and valued the service they provided. They told us they were happy and motivated to provide high quality care. Staff told us they had opportunities to put forward their suggestions and be involved in the running of the service. One staff member told us, "I would

recommend here for my family." On display in a communal area was a schedule of forthcoming 'friends and family' meetings to be held during 2016. This gave family members an opportunity to comment and make suggestions on the service in a formal setting.

We also saw one person with an incomplete risk assessment. Their assessment had been recognised as high risk of falls and they had sustained four falls during a two week period recently. We found no review of this risk assessment following the falls.

We saw fire safety was not always being followed. We saw one fire door with a sign indicating the door was to be kept locked and we found the lock open. We also observed a fire escape was obstructed due to its use as storage for equipment and wheelchairs. These concerns would have been identified with a robust audit of fire equipment and systems.

We found a number of discrepancies still remained with care record documentation. Some sections of care records were poorly completed and contained insufficient information. Although the registered manager was already aware of this following a car record audit in January 2016, no action had been taken. For example, we found one person's daily record indicated they had three skin tears and they were to be monitored. Their care records had not been updated to reflect this change in need and consequently their pressure relieving mattress was set at the wrong setting. This action may have been avoided with prompt updates to reflect people's current needs.

This was a breach of Regulation 17 (2b) (2c) of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations.

The registered manager and another senior manager from the provider played an active role in quality assurance and to promote continual improvement in the service. They used a range of audits to check the quality and safety of service people received. This included checks on housekeeping, water temperatures, kitchen and nutrition, night time checks and various checks on the safety of the premises. As a result of these audits, one agency member of staff was stopped from being used and audits are being reviewed to improve actions and communications. This showed us the service did look for lessons that had been learnt.

People's care records were audited six monthly to make sure people received their care as outlined in their care records. The provider and registered manager drove improvement for the benefit of people who lived at the service. There was on going refurbishment of bedrooms and ensuite facilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person centred care was not always consistent within the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Accidents and incidents were not always reported to the Registered Manager and reviewed for trends in a timely way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Robust checks of the service and documentation were not being used as they had not identified areas of concern.